UNICARE®

1350 Main Street
Springfield, MA 01130-1630

Claim for Personal Accelerated Death Benefit

The furnishing of forms does not constitute an admission of liability on the part of the Company.

Employee Instructions

1. Answer all of Section 2, Statement of Claimant. Print all answers clearly in ballpoint pen. If you change your answer, place your initials next to the correction.
2. Have your doctor complete GA6223 Statement of Attending Physician. You can get this form from the employer. Also, include lab results and x-rays, if applicable. The x-rays will be returned to the physician.
3. If applicable, provide the following documentation:
   - If you are divorced, a copy of the court approved divorce settlement agreement.
   - If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary, for payment of a personal accelerated death benefit.
4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

Employer Instructions

1. Check that the employee has completed, dated and signed this claim form. Verify that all required documentation has been provided.
2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.
3. Complete all of Section 1, Statement of Employer.
4. Include a copy of the employee's signed application card.
5. Send this claim form and all required documentation to:

   UNICARE LIFE & HEALTH INSURANCE COMPANY
   LIFE CLAIM UNIT
   1350 MAIN ST
   SPRINGFIELD MA 01103-1630

Section 1 Statement of Employer

GROUP POLICY NUMBER	SUFFIX #	COMPANY	ADDRESS/CITY, STATE/ZIP CODE
22839	00	U.S. Army NAF	P.O. Box 107, Arlington, VA 22210-0107

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	MARITAL STATUS
		☐ Male ☐ Female		☐ Married ☐ Widowed ☐ Single ☐ Divorced

ADDRESS OF EMPLOYEE (Number & Street, City, State, Zip Code)	EARNINGS (wkly)	AMOUNT OF INSURANCE
	$	

DATE ENTERED FULL-TIME EMPLOYMENT	EMPLOYED IN CAPACITY OF:
DATE LAST PHYSICALLY AT WORK FULL-TIME	REASON FOR LEAVING WORK:

IS COVERAGE CONTINUING ON A PREMIUM PAYING BASIS?	IF "NO," WHAT WAS DATE OF LAST PREMIUM PAYMENT?
☐ Yes ☐ No	

NAME OF BENEFICIARY	RELATIONSHIP	AGE

ADDRESS OF BENEFICIARY (Number & Street, City, State, Zip Code)

SIGNATURE OF EMPLOYER	EMPLOYER'S PHONE NUMBER
TITLE	DATE

Section 2 Statement of Claimant

All questions should be fully answered by the insured or his legally appointed guardian or committee.

NAME (First, Middle, Last)	BIRTHDATE (Mo, Day, Yr)

LEGAL ADDRESS (Number & Street, City, State, Zip)

STATE NATURE OF QUALIFYING MEDICAL CONDITION:

INDICATE DATE THAT YOU LAST PHYSICALLY WORKED (MO, DAY, YR):	INDICATE AMOUNT OF BENEFIT NOW BEING CLAIMED:
	$

Are you in the process or have you converted your Group Life Coverage to an Individual Policy? ☐ Yes ☐ No

Names and Addresses of Physicians Who Have Treated You for Qualifying Condition	Dates of Treatment

UNICARE reserves the right to request an Independent Medical Examination at the Company's expense.

Have divorce proceedings ever been instituted by or against you? ☐ Yes ☐ No If so, when and where?

(If you answer yes to this question, please see #3 of Employee Instructions on the reverse side of this form.)

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ☐ Yes ☐ No

Enter the taxpayer identification number in the appropriate space. For most individual taxpayers, this is the Social Security Number.

Social Security No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___ or Employer ID No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Certification - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions - You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

SIGNATURE OF CLAIMANT	DATE	RELATIONSHIP TO INSURED

MAILING ADDRESS OF CLAIMANT (Number & Street, City, State, Zip)

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institution or person who has attended or examined me to disclose to the UNICARE Life & Health Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

WITNESS	DATE
SIGNATURE OF EMPLOYEE	

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

For Use By UniCare Only

EXAMINER	CLAIM #	DATE APPROVED/DENIED	BRANCH	TOTAL-BENEFIT AND INTEREST

UNICARE®

1350 Main Street
Springfield MA 01103-1630

Accelerated Death Benefit Attending Physician's Statement

PATIENT'S NAME (please print)	DATE OF BIRTH
PRESENT ADDRESS (Number & Street)	SOCIAL SECURITY NUMBER
(CITY, STATE, ZIP)	
NAME OF PATIENT'S EMPLOYER	GROUP POLICY NUMBER
U.S. Army Nonappropriated Funds	22839

Attending Physician's Statement of Disability

The patient is responsible for completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers. If #5 is not completed in full, claim processing will be delayed.

		Mo.	Day	Yr.
1	HISTORY When did symptoms first appear?			

2 PRESENT CONDITION

(a) Subjective symptoms

(b) Objective findings

Include results of current x-rays, EKGs or any other special tests relevant to your judgement of prognosis.

(c) Is patient ☐ Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital Confined?

3 DIAGNOSIS

		Mo.	Day	Yr.
4	TREATMENT (a) Date of first visit for above condition			
	(b) Date of most recent visit			

5 PROGNOSIS

"In my best medical judgement, the above patient's life expectancy is _____ months or less, or not more than _____ months"

6 MENTAL CONDITION

Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

REMARKS

ATTENDING PHYSICIAN'S NAME (please print)	DEGREE
ADDRESS (Number & Street)	
(City, State, Zip)	TELEPHONE
ATTENDING PHYSICIAN'S SIGNATURE	DATE

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

To the Attending Physician: *Please mail this report directly to the address shown below.*

UNICARE LIFE & HEALTH INSURANCE COMPANY
LIFE CLAIM UNIT 7S-3
1350 MAIN ST
SPRINGFIELD MA 01103-1630